

# THE ROAD TO BETTER RURAL HEALTH

PLANNING

MOBILIZING  
RESOURCES

STUDYING  
NEEDS AND FACTS

DEVELOPING  
GOOD  
PROGRAMS

EVALUATING  
RESULTS

RECHARTING  
COURSES

SUMMARY - CONFERENCE OF  
EXTENSION HEALTH EDUCATION SPECIALISTS

Denver, Colo., March 2-5, 1952



UNITED STATES DEPARTMENT OF AGRICULTURE  
Extension Service  
Washington 25, D.C.

## FOREWORD

THIS is a summary of the papers and discussions presented at the conference of extension health education specialists, which was held in Denver, Colo., March 2-5, 1952 in conjunction with the Seventh Annual National Conference on Rural Health of the American Medical Association.

SUMMARIES of 3 such extension health conferences are now available. A composite index of the topics they include is given on the next page. Together they make up a body of information on concepts and practical aids for program development and methods which should have lasting value for State extension services who wish to further develop present or establish new extension work in the field of health education, and especially for health education specialists themselves.

PROGRAMS relating to health have long been included in Cooperative Extension Work. But it is only in the last 7 years that a specialized health education program on a project basis has become generally known. Today 18 States have such a program, and several others do a good deal in this field through other assigned personnel. It is doubtful if any other new extension program has had such rapid growth in such a short span of years. Health education in the name of health is readily becoming an accepted and integral part of extension work throughout the country. And much progress can be seen State by State over a 5 or 6 year period in terms of understanding of the staff, activities carried by county groups, things accomplished, cooperation with the medical people and health agencies, and in the interest of the people themselves.

SUCH A PROGRAM needs to be a balanced program - one that especially includes information and assistance on family health practices as well as on community health services and public programs, and by leader training as well as by other methods. After all, the main solution to problems of inadequately available and high cost of health services and medical care is for people to be better prepared to take care of themselves. Thus, there is now and always should be a large place in this extension health education program for subject-matter teaching in such fields as home care of illness, home safety, first aid, sanitation, chronic disease attention, children's health, and other preventative family health practices, as well as in the fields of community health services and larger public programs.

THE EXTENSION HEALTH EDUCATOR tries to continually develop himself as an extension worker, and his basic function is to give leadership to the development of health education as a part of the total extension program of the State and of the counties. He teaches health subject matter. He opens channels of communication with various health resources. He helps extension agents and the people plan. He is an evangelist, a middleman, and a catalyst. And in all this he is guided most of all by the policies and conditions of his own State extension service and situation.---EJN

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ENROLLMENT AT EXTENSION HEALTH EDUCATION SPECIALISTS' CONFERENCE  
Denver, Colorado March 2-5, 1952

State Extension Personnel

Arkansas	- Helen Robinson, extension health education specialist
Colorado	- Clara Anderson, Acting State Home Demonstration Leader
	- May Stanek, extension nutritionist
Georgia	- Lucille Higginbotham, extension health education spec.
Illinois	- Pauline Brimhall, extension health education specialist
Indiana	- George Nuffer, extension health education specialist
Iowa	- Merl I. Whorlow, extension health education specialist
	- Margaret Kagarice, district supervisor
Kansas	- Martha Brill, extension health education specialist
Michigan	- David G. Steinecke, specialist, health and safety organ.
	- Paul A. Miller, extension rural sociologist
Mississippi	- Annette Boutwell, extension health education specialist
Montana	- Frances Macdonald, extension health education specialist
Nebraska	- Helen L. Becker, extension health education specialist
Nevada	- M. Gertrude Hayes, rep. State home demonstration agent
Oklahoma	- Esther Martin, district home demonstration agent
Oregon	- Frona Yeager, extension health education specialist
	- Mabel C. Mack, assistant director
South Dakota	- Esther Farnham, assistant state home demonstration lr.
Utah	- Thelma Huber, State home demonstration leader
West Virginia	- Gertrude Humphreys, State home demonstration leader
Wisconsin	- Edith Bangham, assistant state home demon. leader
Wyoming	- Evangeline Smith, extension nutrition and health spec.

Resource Persons and Participating Guests

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 E. J. Niederfrank, Extension Rural Sociologist, USDA, Washington, D.C.  
 Jean L. Pennock, Family Econ., Bur. Human Nutrition & Home Econ. Wash. D.C.  
 F. W. Peck, Managing Director, Farm Foundation, Chicago, Ill.  
 Madge Reese, Field Agent, Extension Service, USDA, Wash. D.C.  
 Audrey Sanstead, Assistant State 4-H Club Leader, Ft. Collins, Colo.  
 Mabel Smith, Nat'l Committee on Boys and Girls Club Work, Chicago, Ill.  
 Jessie Heathman, Radio Dept. University of Illinois, and chairman of the  
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SUMMARY - CONFERENCE OF  
EXTENSION HEALTH EDUCATION SPECIALISTS<sup>1/</sup>

OPENING STATEMENT - SOME BASIC PRINCIPLES

By F. A. Anderson<sup>2/</sup>

In a bulletin "Do We Want Health?" published by the University of Nebraska Extension Service in 1940, Miss Elen Anderson wrote:

"When the leaders among the people and the physicians in each community, as well as in the State, study together questions of health security, with mutual respect for their responsibilities, there is hope that a health program will be built that is satisfactory both to those who serve and those who are served."

This is a principle of both Extension work as a whole and of extension health education. It is an excellent premise upon which the meetings of the Council on Rural Health of the American Medical Association was held in Denver during the past three days, and upon which the Conference for Extension Health Education Specialists, starting today, is predicated.

As Extension workers, we are primarily concerned with the development of the most effective ways and means of persuading and assisting people with whom we work to adopt improved practices in Agriculture and home economics and to assist in the solution of their social and economic problems, including rural health.

Formal education has been defined as "the acquisition of knowledge, skill, or development of character, as by study or discipline." Another definition is that "education is the sum of the qualities acquired through individual instruction and social training."

The most specific interpretation of education as it applies to Cooperative Extension Work in Agriculture and Home Economics is the language that we are all familiar with, as incorporated in the Smith Lever Act," namely, "to aid in diffusing among the people of the United States useful and practical information on subjects relating to agriculture and home economics and to encourage the application of the same." The attainment of this objective cannot be accomplished without adequate knowledge of fundamental psychological principles and their application to make methods that are employed in Extension education most effective.

<sup>1/</sup> Prepared by E. J. Niederfrank, Extension Service, United States Department of Agriculture, and Helen L. Johnston, U. S. Public Health Service, from the notes of discussion group recorders and copies of papers with some additions and interpretations here and there. May 1952.

<sup>2/</sup> Director, Agricultural Extension Service, Colorado A & M College, Ft. Collins.

The fundamental principle underlying Extension education, as enunciated by Dr. Paul J. Kruse, Professor (Emeritus) of Extension Education Cornell University, is that it "is the production of changes in human behavior," and that these changes may be classified as:

1. Changes in knowledge or things known
2. Changes in attitudes or things felt, and
3. Changes in skills or things done.

"Good Extension teaching," he says, "is arranging situations so as to get behavior that will result in desired changes in one or more of the above. We learn only what we do - not what the teacher does, but what he causes the learner to do." Oftentimes a change in No. 2 has to be produced before much change in knowledge or practice results.

Some psychological factors enumerated by Dr. Kruse in motivating human behavior are that fundamentally people want:

Health	Companionship
Security	New experience
Recognition or approval	Self assertion

Still other quotations that apply to the purpose of this Conference are one by former President Franklin D. Roosevelt in which he said "to accomplish anything worthwhile, there must be a compromise between the ideal and the practical," and one from Kolb and Brunner, in their book "The Study of Rural Society," which says that "the naive assumption that any group of persons will fall in with any plan about which they have not been consulted has been proven false so often in history that its survival is one of the world's mysteries." In other words, you have to include the people in the planning of a program if you want their wholehearted support. We know that is basic in extension work.

This Conference, I am sure, will be another milestone in the progress that is being made in "building the road to better rural health."

#### I. PLANNING THE COURSE - SOME IDEAS FOR HOW AND WHAT AS I VIEW IT

Frank W. Peck 3/

Three problem areas concern me along this line. The first is what should Extension teach in the field of health and how do it? What is the logical priority to meet essential needs? How can you get together in most practical fashion the existing resource material?

Extension has earned its place in the sun by objective education - the teaching of facts. But new techniques are needed in the area of health education just as in the area of public policy. How can

we best develop techniques that will stimulate people to want to help themselves?

Financing essential medical care is a second problem area. It is generally said that people can have anything they want if they want it badly enough. In a period of declining income and less spending, how can you develop in people a sense of values as to priority of use for limited funds? This area needs a great deal of study. It is not easy even for many of the fairly well-to-do middle class families to pay for emergency health expenses out of family earnings. Perhaps we can develop different types of pooled insurance in which we depend upon the abilities and resources of communities to solve their financial problems in the field.

Recruitment and training is a third problem area. In extension health education there is a problem of recruitment and training. Training for many types of relationships that people do not obtain in college courses is needed. Recruitment of personnel for manning health facilities is part of this problem. Many rural people have not understood why it takes so long to train a doctor. The Northern Great Plains Council is developing a project for recruitment and training of nurses. The recruitment and training of local leaders is still another part of the general problem. The seeking and developing of local leaders in their own communities needs to be strengthened.

Aubrey D. Gates 4/

Probably 99.9 percent of what Extension does results in some benefit to health in one way or another. In many cases an agricultural program enters the field of health indirectly. For example, REA got into the plumbing business in Arkansas in order to avoid the unhealthful conditions resulting from getting running water into the house by electricity and not making any provision for waste disposal.

The goal of Extension is a healthy family—healthy physically, mentally, and in every other aspect. The fundamentals of a good health program for family and community are adequate nutrition, sanitary environment, immunization, family care and prevention of illness and accidents, availability of adequate medical care including hospitals and medical personnel, and some kind of a pre-payment program.

The main question is, How can we mobilize our own staffs to do this job? How can we mobilize State and field staff to gain understanding? Every extension worker should understand the broadness of the health education program. He should know the other agencies and organizations which are also in the field and what part they play. County staffs also need to understand. The public health nurse, sanitarian, or similar worker frequently can be used to

4/ Field Director, Council on Rural Health, Amer. Medical Ass'n., and formerly Associate Director of the Agricultural Extension Service, University of Arkansas, Little Rock.

provide the detailed teaching required. Extension is the catalytic agency which brings these services in contact with local people.

The American Medical Association is trying to reach as many doctors as possible and explain how Extension operates. The doctor is a citizen of the community. He must first practice good medicine and then counsel with others in planning for health on a community basis. Extension health education can and is helping facilitate that process.

Frank L. Ballard 5/

Let us look at three things about Cooperative Extension Work. These are (1) Why or what is it, (2) How, and (3) Courage.

Why or What is it? Extension is financed by the Federal government and by the States and counties. It is truly what the name implies - Cooperative Extension Work. Today some believe it the most effective adult education program ever conceived. There was some unfavorable reaction to extension when it was first set up in 1914, even though it was established in response to a growing demand by our people out in the counties. People at that time were not interested in the abstract. They wanted specific help in agriculture and home economics.

As other agricultural programs started, people wanted to know about them, too, such as about the philosophy behind soil conservation, price controls, marketing and subsidies. They asked about community organization. "Should we have a Grange, Farm Bureau, or Farmer's Union?" Extension could say, "We believe in farm organization; these organizations have different policies and programs. It is for you to decide among them."

Health work has also come into extension in keeping with this gradual broadening of extension work as a result of the demands of the people. If extension is to remain vital, it must be ready to assume responsibility for these broader programs.

How? We talk with small groups of 10 to 15 in the county to discern needs and interests. Out of these discussions develop a program. Extension will be liaison between rural people and established movements already under way. It may have suggestions from various communities as to some modifications of programs of other agencies. Programs vary in the counties because they start with the people locally. You have to sense the thinking of the people.

In developing the health education program, courage will be needed. Every new program meets opposition. Effective teaching may bring about changes and therefore reaction among those asked to change. For example, State medical organizations may not like some of the changes suggested. We need to understand that not all change is "socialized medicine."

The challenge is up to the Extension Service and other groups in the States. If they fail to meet it, then people will look to the Federal government for help in meeting their health problems.

Courage is needed to build a health program by sitting around the conference table with the people concerned based on their needs. We need to call in representatives from various organizations and agencies. We should expect some opposition. Adjust as may be necessary and carry on. If Extension runs away from this new field, it is failing in its responsibility to help rural people help themselves.

Carmen Johnson 6/

Home demonstration agents have many contacts with rural people through meetings, home visits, news stories, office visits, and radio. They bring health into various activities and projects because it is interrelated in so many cases. They work with the individual, the family, and the community. To meet individual needs they promote better nutrition, immunization against disease, health examinations, and other activities. Family activities include wholesome family relationships, beauty in the home, sanitation, family insurance, home care of the sick, and first aid. In the community, their programs include blood typing, mobile x-ray unit, school hot lunches, sponsorship of the March of Dimes, and other activities.

The home demonstration agent brings health in its broadest aspect into the rural home. The field is broad and includes good government, community libraries, and many other activities which help build good mental health and morale. Rural people are interested in health and they want all that we can give them on it.

The extension health educator has a real challenge and opportunity to work with the home demonstration agents in his or her State. Gain their respect by appreciating what they are doing and adapting to the county conditions and extension organization and helping them with the practicalities of the job. They will welcome your help to help them serve their rural people.

Helen Becker 7/

Extension health educators must have a definite program. They must learn from the people their felt needs. These needs must be met with the best knowledge they can bring together. They must also integrate health into all phases of extension work. They must also coordinate and dovetail programs of other agencies and apply them to the needs of the people. Sound programs start with the people and end with the people. The more of the State extension health programs that come up through the regular extension programs planning process and involve both Staff and leaders, the better.

6/ Home Demonstration Agent, Larimer County, Colo., Ft. Collins, and 1952 president of the Nat'l. Ass'n. of Home Demonstration Agents.

7/ Extension health education specialist, Agricultural Extension Service, University of Nebraska, Lincoln.

## II. MOBILIZING RESOURCES

General group discussion led by a subcommittee with Mabel C. Mack of Oregon as chairman. Two topics were considered - mobilizing within extension through a State extension health committee and mobilizing of the people locally through health councils.

### State Extension Health Committees

Several States report having such a committee. Membership includes representatives from home demonstration, agriculture and 4-H administrators, rural sociology, and subject-matter programs especially related to health, such as nutrition, agricultural engineering, and veterinary. In Iowa the committee started with a rather large membership and has since been reduced to a smaller number. The committee was originally established on the suggestion of a State advisory committee including representatives of farm organizations who wanted the extension service to do something in the field of health. In Oregon the committee started small and was later expanded. It was suggested that a couple of county extension agents also might well be included on the staff health committee.

One extension committee started by surveying the work of extension specialists to see how many included some aspect of health in their program. They found that 17 specialists did. From there they moved to a study and discussion of the health needs of the State and the need for a health specialist. Finally they decided to get a specialist and made an effort to determine how a health specialist might be effective in tying together all of Extension's health effort.

Listed as functions of an extension health committee were:

Planning before a health specialist comes.

Formulating a policy statement and objectives on health education.

Getting the cooperative support of extension staff members for this new type of health education program.

Developing understanding among groups outside extension.

Giving guidance to the new health education specialist.

Getting county agents and men specialists to accept health as more than a woman's job, and getting them active in health work.

Helping 4-H programs to include functional health education.

Getting the health aspects of various programs brought out in clear focus and taught more in terms of health.

Some of the problems of extension health committees as they now operate include:

Difficulty in getting the committee together.

Maintaining interest. (Suggestions for meeting this problem included conducting meetings in a business-like way; sending minutes to all committee members; calling meetings at times when most people will be in; planning meetings and programs well; planning for rotation of committee members.)

Too large a committee which may be unwieldy and may fall apart.

Some essentials for a good committee were suggested: (1) strong administrative support and follow through, (2) having committee meetings included on the master schedule, (3) concrete accomplishment, (4) obligation of the specialist to keep all members of the committee informed, (5) committee members, in turn, responsible for disseminating information to other staff members of program they represent. Selection of committee members - choosing those with status from among the States and county staff - was believed important.

Instead of an Extension-wide health committee, one State has a health committee of county agents and home demonstration agents. Another has a 4-H health committee including leaders, agents, and staff members. In some States the specialist confers informally according to specific activities with other staff members, instead of having a formal organization. In others regular monthly staff meetings are held with a different specialist responsible for the program each time. The health specialist serves regularly in turn and in this way is able to discuss the health program with the staff. Mississippi has a State extension community development committee of which health work forms a part.

Whether or not a formal organization was set up within the State extension and college staff, the group agreed that the type of activity described as carried on by extension health committees was essential to building a well-rounded extension health education program, to integrate and develop the human health aspects of the various extension programs to gain better understanding and support of the role and program of the extension health education specialist at the State level and in the counties and to join with other staff members on cooperative endeavors. Much of all this may and is being performed in some States on an informal basis between the health education specialist and others as occasions arise. The main thing is that these functions somehow get performed as needed.

#### Health Councils

Seven of the States represented reported having State health councils; 13 have county health councils. In general the councils are composed of representatives of all public and private agencies and organizations interested in health.

The group agreed that a formally-organized council is not essential to carry out an effective health improvement project. Many counties have developed and carried out projects without one. A felt need on the part of a representative group is essential before a council is organized. The solving of a generally recognized problem can become an objective for effective council organization.

The end is the important thing and it is the problem under consideration, while the council should be thought of as a means to an end, but not the end itself. Extension assists in the formation and work of health councils where needed, but does not promote councils just for council sake.

The county agent's part in a county health council varies. He may take part all along the way, including paving the way for the health specialist to come into a county. On the other hand, his own role may not be strong but he may identify local leaders who can assume responsibility. In any case, Extension should have a part in a health council, if and when one is formed, as so much of what a council ought to do is generally related to one or more extension programs.

Some suggestions for health councils from the discussion include:

First, make sure that a recognized health problem is faced.

Call together interested individuals and agencies.

See if other existing groups can do the job that is needed.

Local lay leadership is of great significance; guidance is important, but too often there are too many professional people and too much pushing by special interests.

Small town businessmen are too often overlooked by extension; they should be involved; rural and urban health interests are closely tied together in many counties.

The specialist may provide information about a health council and facilitate discussion. He has a responsibility to help appraise the demand to organize; but the decision to organize a council should be a local decision.

A health council should be recognized as a tool and not an end in itself.

It may be necessary to break down county lines to include several counties within a single council; an alternative is to have joint meetings of several councils within the same general area. (One Wisconsin county has an association of community councils; in Montana, adjoining councils have held district meetings to begin development of pub health services.)

### Special Organization for Special Jobs - Other

There are still other ways of mobilizing resources, such as setting up a special committee for a special problem or adding the function to some present committee or group. The main thing is leadership or initiation for considering the problem. This can best start in some already existing group or institution, and from this suitable organization set up to deal further with the problems raised.

Organization should never be promoted as an end in itself. The first thing in initiating the facing of a problem and setting up organization for further action is to see what already exists for doing the job. Maybe there is already some kind of over-all organization such as a community council or a county extension planning group, which can best do the job without a separate health council having to be formed. Or, a health council may grow out of first some special organization for a special problem. Such growth is more sound than to start by first promoting the organization itself. On the other hand, if the community is a sizable one, and various problems or needed actions are evident, the formation of a council to get teamwork and action immediately can be properly undertaken. Above all, teamwork is needed today in the facing of most rural problems. But that teamwork should be brought about according to the case and situation.

### III. STUDYING THE NEEDS - RURAL HEALTH FACTS

An important role of the health education specialist is interpreter of facts. This session included two resource papers, followed by general discussion led by Paul Miller of Michigan.

#### General Population and Health Facts

By Jean Pennock <sup>8/</sup>

Some of these facts show who our customers are with implication as to health needs, while other statements are more directly health facts.

1. About 40 percent of our farm households have no children, 20 percent have 1 child, 15 percent have 2 children, somewhat more than 10 percent have 4 or more.
2. There has been an astonishing increase in the number of young children in the population as a result of the sharp rise in the birth rate during and after World War II, the proportion of older people is increasing. The increasing elderly group is a result of the longer life span science is giving us, and also the result of another of those sudden spirals in the birth rate back in the two decades following the Civil War.

<sup>8/</sup> Family economist, Bureau of Human Nutrition and Home Economics, Washington, D.C. A fuller summary of this topic, including charts, has been prepared as a separate statement.

3. In spite of the general high level of income, in 1949 about 34 percent of the farm families had net money incomes under \$1,000, not including non-money items, and 78 percent had incomes under \$3,000. Only 11 percent had net money incomes over \$5,000.
4. Records of farm families that submit home accounts to the State colleges annually - probably upper income families - indicate that farm family expenditures for medical care are 300 percent of what they were in 1937. This does not necessarily mean a corresponding increase in volume of medical care received as inflation has affected medical care costs, too. But there has been definite increase in the volume of medical care used by farm families.
5. Infant mortality is one of the best general over-all indexes of the level of health. In 1948 there were 26 States which had less than 30 infant deaths per 1,000 live births and 2 States had 70 or over. In general, infant mortality is higher in the Southern States than the Northern, partly because of the racial factor and partly because of the larger proportion of rural population.
6. In 1949 the ratio of physicians to population was more than three times higher in the greater metropolitan counties than in isolated rural counties - 50 physicians per 100,000 population compared to 173.

The distribution of physicians is not constant around the country. Of the four main Census regions, the South has the lowest ratio, 89 physicians per 100,000 population, and the Northeast the highest, 158 per 100,000.

The increase in physicians did not quite keep up with the growth of the population from 1940 to 1949; the ratio of physicians to population for the U. S. as a whole fell from 122 to 119 per 100,000 persons in that period. And the worst of it is that those areas with the most unfavorable physician ratios in 1940 or who could least afford to lose, were those that lost the most in the ensuing years. Of course, <sup>local</sup> ratio does not tell the whole story, for rural families can more easily go to where the doctor is than a generation ago.

7. There are relatively more older men among rural physicians. This means that physically they may not be able to do as much, that they may not be so well abreast of recent medical developments, and that the level of care they give may not be as high.
8. Another measure of the relative health status of rural and urban people is the proportion of the population losing time from work or other regular activity because

of illness. A recent survey made by the Bureau of Agricultural Economics of the USDA indicated that in 1948 farm operators themselves lost 80,000,000 man-days on account of illness and 17,000,000 man-days on account of accidents. These amounts of losses we cannot afford in any year and particularly not during these times of shortage of farm labor and medical personnel to care for illness or accident. A study in Michigan shows that 18 percent of the people living in the open country lost time because of illness as compared to 10 percent for the metropolitan area.

9. As of 1950, about 50 percent of our total population had some form of health insurance. Virtually every person covered by such insurance was covered to some extent for hospitalization. Other types of coverage were carried by smaller proportions. About 1 in 3 had some surgical coverage in addition to their hospitalization, and an additional 14 percent had some medical coverage. Only a very small proportion had comprehensive health care insurance. It is known that a smaller percent of rural people are covered by some form of health insurance than urban, but the rural rate is increasing.

On the whole, the health picture for the rural U.S. is good. However, the over-all picture should not delude us into complacency. There are still many problems to be solved before all rural people attain the level of health enjoyed in most advanced areas today. These are problems of education, low income, and poor facilities. To overcome these handicaps will require the cooperation of government agencies and cooperation of public and private agencies - Federal, State, local - and leadership and cooperation among the rural people themselves.

#### New York and Mississippi Health Studies

By Donald G. Hay 9/

The studies included in Mississippi 909 rural families comprising 3,500 individuals in four sample counties, and in New York 1,500 families comprising 5,500 individuals in six sample counties. Reports were based on personal interviews, always with an adult member of the household and usually with the homemaker, and the interviewers were people living in the county, mostly former teachers, public health workers, and rural leaders. Some of the findings were:

1. In New York, 9 out of 10 families had used some medical care service during the period covered by the survey. Dwight Sanderson studied one of the same New York counties 25 years ago and we found that the rate of calls

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9/ Social scientist, Bureau of Agricultural Economics, headquarters Department of Rural Sociology, Cornell University, Ithaca, N.Y.

for physicians has approximately doubled in 25 years. Four times as many families use a hospital. The percentage of births occurring in hospitals has increased from 30 to more than 90.

2. The use of health services is associated with the following factors: age, sex, race (in Mississippi), residence, occupation, income, socio-economic status, and social participation. The "higher" the family level is in all these, the more likely one is to use established health services. Your educational problem is to get the others to do so. The rural non-farm resident was the heaviest user of medical service, and the farm resident relatively the lowest user. Income is the factor which shows the most marked and most consistent relationship to the extent of use of medical care. Self-motivation is important, particularly in the use of preventative health care. The educator, especially in the field of health, has to give great emphasis to motivating people to follow recommended practices. Inertia has to be overcome; also the feeling of not belonging or being wanted because of lower income or some other factors of "low" status.
3. In Mississippi, health insurance other than accident protection was held by over 3 out of 10 families. In New York 5 out of 10 families had some type of health insurance. In areas where heads of households were employed in industrial groups covered by health insurance of some type, health insurance protection was most frequent.
4. A person or more in only 6 out of 10 households in New York went to a dentist during the preceding year, and in 5 out of 10 households in Mississippi.
5. Main sources of information about health services reported by the families interviewed were the family doctor and relatives, with newspapers and periodicals reported frequently in New York Counties. In one New York community, 18 organizations had had some type of health care activity during the last year. About 3 out of 10 households did not know whether or not their county had a public health department or much about it.
6. In Mississippi, the study shows that the location of a doctor does not necessarily determine the place where people purchase their medical care. It indicates that people sometimes bypass the local physician to go to one in the next larger place. It also shows that county lines are crossed in obtaining medical care.
7. Many people between the ages of 25 and 45 in the Mississippi Delta were found to be using the hospital. These included men hospitalized as the result of accidents from use of mechanized equipment for which they were improperly trained.

This also shows the need for training people to use equipment before it is put into the field.

Discussion. It was suggested that health council organizations might be formed along the lines of medical care trading patterns rather than counties. The comment was made that there is little correlation between the desires of the people for local medical service and their trade patterns. It was also suggested that age and other indications of the quality of care might explain to some extent the bypassing of the local doctor.

In one State experience has shown that a community which has both a hospital and a doctor can counteract other trading tendencies and get the trade. The provision of hospital services seemed to lead to less bypassing of the local doctor.

A change in customs was pointed out as affecting medical care patterns in Arkansas where the older doctor may charge \$2 per visit and may be paid in eggs or other produce. He has no expensive equipment. The young doctors with the equipment may find essential cannot afford to provide care for \$2. People need education along the line of what modern medical care means in terms of costs and facilities needed by the doctor.

The problems of young doctors who go into rural communities long enough to attract a local practice and then move on was referred to. They may go to a nearby larger center and continue to attract people from the rural community but usually it will be the better paying patients.

The problems of meeting hospital-bed needs and not overbuilding were also discussed. In one State, it was stated, more than 4.5 beds per 1,000 population are now needed based on current patterns of use of hospital care. On the other hand, another State had experienced overbuilding in some areas. Local pride and the local doctors' wish for a hospital are two factors that lead to this situation and have to be dealt with thoughtfully by the community.

#### Community Self-survey, A Way of Discovering Facts and Motivating People

Discussion led by David G. Steinecke of Michigan. He referred to the pilot county idea developed at the 1950 workshop at Kansas City. Points brought out indicated the values of a pilot county in enabling extension workers to get fully acquainted with one local situation in order to better understand situations elsewhere. Other advantages included providing a proving group for an activity, a point around which to organize an extension health committee or a State rural health committee in case none existed, a point to focus on in discovering the resources of the local community and in discovering how a health program can become an integral part of an overall comprehensive plan for a county. A pilot county might also serve as a demonstration which would make for better understanding within and outside Extension of the role of the extension health education specialist and of the new type of extension health program.

The remainder of the discussion was concerned with Lenawee county, selected as a pilot county in Michigan with a health survey being an initial step. The pilot operation demonstrated both what was effective and what proved to be pitfalls for the extension health education specialist. The decision to interview all families was made locally in spite of the suggestion that a sample would provide the answers needed. An extensive training program was undertaken for interviewers with the assistance of a Grange group which put on demonstrations of how to get the information desired. A problem that is still unsolved is how to get the cooperation of the city of Adrian. Another problem that was not met adequately in the beginning and which has proved a handicap is the lack of a strong local sponsoring organization. Lenawee county was unwilling to wait to build up such an organization. The specialist had to do much of the work.

In spite of the aspects in which it has not been wholly successful, the pilot operation helped to make a place for the health education specialist in Michigan. It has also provided material for a manual on "How to Conduct a Community Self-Survey of Health" to be used to help other communities interested in making such a survey in their own areas.

The question was raised as to how much time should a State extension health education specialist devote to making county or community health surveys? Much depends upon the form in which his or her program is developing in response to demand and to factors in the college and State situation. Here again, it is a matter of it being a tool to solve problems. Surveys should not be promoted as an end in themselves. But they are an essential or good early step to a systematic educational program for improving both community health and family health practices. How systematically such a complete program needs to be developed at the outset is a question. Often programs best develop a piece at a time. On the other hand, the family-community approach is generally needed in order to reach and motivate more people, and a survey is a good beginning for such an approach. But even the survey has to come from previous teaching, out of which a group of some kind decides to take further action including a survey.

Surveys should be kept simple, and their development never taken too far out of the hands of the people. Their motivation value is one of their greatest values. One or two a year as demonstrations may be the desired thing, out of which can come guides for other communities studying sufficiently their own needs themselves with mainly the help of the county extension staffs and other local resources only.

#### IV. : DEVELOPING GOOD PROGRAMS - SPECIAL

To a large degree the discussion of this topic with Frances Macdonald of Montana as chairman, was again concerned with Extension's responsibility as interpreter of facts.

It was pointed out that in developing good programs, extension needs information on a number of subjects. It needs to get acquainted with the public health services available, the types of services offered,

cost and personnel. If there are no public health services locally, it needs to find out what the local problems are and how these can be solved. More facts are needed about hospitals and their use, maintenance, financing, staffing, and standards for beds needed. Facts about medical service and use of medical care are also needed. Much can be learned through the medical society, the nurses' association, and other sources. Extension also needs to become acquainted with proposed legislative bills and laws that are passed. In addition, it should know the standards for registration or licensing of nurses, doctors, dentists, and other health personnel. Socio-economic data from the census and other sources are necessary. Knowledge of programs of neighboring States is also required. Voluntary health agencies and what they have to offer is still another area in which extension workers should become informed.

### Prepayment Plans

By Frances Macdonald 10/

Many people consider prepayment for medical care a relatively new thing. Actually, the idea of prepayment is far from being new in the United States. In the late 1800's a number of prepayment plans developed to provide services for industrial workers, chiefly in isolated areas. The plans arose from the need to provide medical and hospital services for these workers just as other essential community services had to be furnished. Many of the plans offered comprehensive services, including physician's services in the office, home and hospital, and hospital care when needed.

During the early 1900's, hospital service plans were formed in scattered communities, usually centered around a single hospital. One such plan was formed in 1929 at Baylor University Hospital in Texas. It turned out to be the forerunner of what is now called the "Blue Cross" plan.

In 1933, voluntary health insurance was still an issue. Prepaid hospital service plans were typically a shoestring operation. Only a handful of people were enrolled in the whole country.

By 1937, the American Hospital Association had begun to take an active interest. A committee was formed by the Association to foster the development of prepaid hospital service plans, act as information clearing house, collect statistics, and perform other functions. This committee was the predecessor of the Blue Cross Commission. An increasing amount of hospital and surgical insurance was also being written by commercial insurance companies.

During the 1940's, interest in surgical and medical insurance, particularly for hospitalized cases grew rapidly. In 1946, the Blue Shield medical care plans were formed to carry on functions for medical-society sponsored surgical and medical care, similar to those of the Blue Cross Commission for hospital service plans.

By 1946, the principle of voluntary health insurance had been accepted by both the American Hospital Association and the American Medical Association, provided the plans were under hospital or professional sponsorship. In that year, however, another national organization interested in prepayment plans was formed—the Cooperative Health Federation. Its objective was to support the right of consumers of medical care to take the initiative in developing prepayment plans. This is still an issue in the field of prepayment.

At present four Nation-wide reporting organizations representing voluntary health insurance plans provide information about the plans. The Health Insurance Council, New York, prepares an annual report of growth in enrollment and current trends among Blue Cross and Blue Shield plans, commercial health insurance, and other types of prepayment plans. Each of the other reporting agencies has headquarters in Chicago. They are namely, Blue Cross and Blue Shield Medical Care Plans, and the Cooperative Health Federation. The State offices of Blue Cross and Blue Shield, also, usually can furnish information for the specific State or part of a State in which they operate.

Voluntary health insurance has taken remarkable strides since the early 1930's. By 1951, enrollment has grown from a handful of people to half the population. According to the Health Insurance Council, of the 77 million persons insured in 1951 against at least part of the costs of medical care, probably all had some form of protection against hospital costs, and about 22 million were protected against the costs of physicians' services—usually for hospitalized cases only.

A closer look at the accomplishments of voluntary health insurance is afforded by the report, "Health Insurance Plans in the United States," published in 1951 by the Senate Subcommittee on Health. A summary was sent to us by our Federal office. According to the report, health insurance predominates in the heavily industrialized States. It is most common where group enrollment with payroll deduction and often with employer contribution is found. In general, it covers mainly the young and able-bodied, those having regular employment with regular pay. To a growing extent, workers' dependents are also covered, but their benefits may be less than those of the covered worker.

There are various estimates of the part of the Nation's total medical care bills paid by health insurance. All of them show a relatively small share paid by insurance in spite of the fact that half the people are reported to have health insurance of some kind. In 1949, the Senate report estimated that insurance covered about 12 percent of all private medical care expenditures. For hospital care, the estimate was about 25 percent and for physicians' services, about 10 percent. Insurance benefits for other medical care items were negligible.

The results of the Senate Subcommittee's study show that among those not generally covered by health insurance are rural residents, older age groups, low income groups, and the handicapped. It also shows that there are gaps in coverage for those who have insurance. For the Nation as a whole, there is a wide gap between total costs of

medical care and the costs borne by insurance.

Much of the future expansion of health insurance will take place in rural areas. This fact makes it worth while to examine some of the points for a rural family or community group to look for in choosing from among the various health insurance plans that may be offered. A family or community group might judge a plan by its probable effect on (1) the individual or family insured (2) the hospitals and professional personnel concerned, and (3) community. In addition they will want to look at the plan itself and consider the soundness of its organization and operation. (Specific criteria for evaluating plans may be obtained from the American Public Health Association, the American Medical Association, and other sources.)

In considering the effect of a prepayment plan on the economic and health status of the individual and the family, questions such as the following might be raised:

Exactly what conditions and what items of medical care costs does the plan cover?

What part of the bill for covered items and conditions does the plan offer to pay for the head of the household? for dependents? If the plan covers hospital care, does it pay full costs or part of the costs? For how long a period will part or all of the bill be paid?

How well does the cost of the plan fit the family budget?

How well does the method of collecting dues or premiums fit local customs and needs according to the way income is received?

To what extent does the plan encourage early care to protect health and possibly reduce lost working time, thereby protecting both the economic and the health status of the individual and family?

In looking at a prepayment plan's effect on hospitals and professional personnel, a rural family or community group might ask these questions:

Does the plan provide adequate compensation for services?

Does it necessitate or encourage short-cuts designed to reduce the level of care to what can be provided for the amount paid?

Does it necessitate or encourage efficient organization to provide care of good quality?

From the point of view of the community, a family or group might ask:

Does the plan encourage efficient and effective use of community health resources? Or does it encourage provision and use of costly hospital facilities that might otherwise not be required, thus subjecting the community to an extra financial burden?

What effect does the plan have on assuring support for needed services? Does it pay hospitals enough to eliminate any need for the community's making up deficits resulting from the unmet costs of care for insured patients? Does the plan help to raise low income groups to a level of medical self-sufficiency?

What effect has the plan on community health? Does it provide service to essentially the same group that have always been able in some way to afford it? Does it tend to extend more services to more people? To what extent does it help to protect and improve health as well as helping to pay bills for health services?

Finally, looking at the plan itself, a family or community group needs to ask:

Is the plan financially sound?

Is it well administered?

Is the cost of administration reasonable in relation to benefit payments?

To what extent are the interests of consumers represented in administration of the nonmedical aspects of the plan?

Is the plan adaptable to the changing needs and wishes of the insured groups?

All the questions that can be raised about prepayment plans boil down to the single problem of helping people pay for needed medical care. By solving this problem the problems of individuals and families in obtaining the medical care they need to protect and maintain health - the problems of hospitals and professional personnel in getting their bills paid - and the problems of communities in securing and maintaining adequate facilities and services would also be largely solved.

Adequate financing underlies the provision and maintenance of adequate care. Until the basic problem of financing can be solved from a family and community point of view, rural communities will continue to have too few doctors, too few and too little-used hospital beds, and too many people in need of both who are doing without.

#### Recruiting, training, and employing nurses

By Henrietta Laughlin 11/

The current lack of nursing personnel can be accounted for by the increased demand resulting from:

1. Additional hospital facilities provided by the Hill-Burton program and other ways.

2. Increased public health units.
3. Expanded health insurance.
4. Early ambulation which fills up hospitals with acutely ill people requiring more nursing care and also adds to need for nursing service in homes.
5. Demands of armed services and veterans' hospitals, chiefly for younger people.

Further factors leading to the current nursing shortage are Nation-wide changes in behavior. Young women are marrying and having babies at an earlier age — leaving the work force. The population is increasing; better working standards prevail in occupational fields other than nursing.

In 1940 there were 85,000 nurses enrolled in schools of nursing in the United States including 38,000 admissions during the year. In 1950 there were 98,000 enrolled including 44,000 admissions. By 1951, admissions had fallen to a little more than 41,000 in spite of a vigorous recruitment campaign by various agencies.

Among the suggested adjustments to the situation are:

1. Training programs for women over age 35 as nurse aids and practical nurses; this would reach a group that is now being employed to an increasing extent.
2. Use of untrained personnel and on-the-job training for personnel in hospitals in administration, making supplies, diet kitchens, and other areas.
3. Shortening the training period for part of personnel.
4. More widespread practical nurse training for adults, and in high schools and colleges.

The Kellogg Foundation is assisting in the development of a program for 2-year nurse and technician training. The same procedure is being followed with social workers, librarians, and others. Canada has a 2-year and a 4-year nurse standard. The 2-year nurse works under supervision; the 4-year nurse acts as a teacher, supervisor, and in other responsible capacities.

There are legal problems in cases of States which have licensing programs which require three years of training. In addition, students are sometimes restricted to training in a hospital. There must also be a policy of employment to fit persons trained at two different levels.

There are opportunities for recruitment among rural girls. The "Future Farmer" idea has been borrowed for "Future Nurses." Vocational guidance for girls in rural schools can include physical therapy, nursing, technicians and similar skill fields.

Extension health education can and is helping recruitment of rural girls and women into nursing fields. Let us stress it more in our radio and newspaper work and in our work with the home demonstration, 4-H, and youth programs.

### Federal Health Legislation

E.J. Niederfrank presented a brief review of current Federal health legislation. No final action has been or is expected to be taken by the 82nd Congress on several bills and subjects, due to other urgent legislative matters at this time, and to special studies of proposals yet to be completed. But more action may be expected in the next Congress on such subjects as medical personnel training, local public health units, health insurance, and hospital facilities. Thus, plans and materials for helping rural people discuss them will be more needed.

There was considerable discussion as to the need to review the proposals critically and to help local people know about and discuss them, having both sides presented in the case of controversial points. Some home demonstration groups and farm organizations have done some good work on this in the past.

The Congress of Parent-Teacher Associations has been the main supporter of the bill for local public health units. Rural people have not been heard from generally as to their opinions about the bill. They need better understanding of the basic functions of public health and how such a department would operate in their county.

School lunch programs were discussed. A question was raised regarding requirements for a school to qualify for State and Federal assistance for a school lunch program. Schools must provide adequate facilities, pay for labor, provide foods to supplement surplus foods, provide transportation and storage facilities for surplus commodities, and meet other requirements. The availability of surplus foods varies with the States.

In general, education activities for discussing public program and policies affecting health are relatively difficult to initiate in the counties. Usable material will help a great deal. Accurate facts and unbiased presentations that give both pro and con viewpoints are basic to this public policy education. We should be interested in all subjects that concern the health of rural people. In doing so we also must recognize other values which people have as citizens and as part of their social institutions.

### V. DEVELOPING GOOD PROGRAMS - 4-H

With Dave G. Steinicke of Michigan as chairman, this session began with the film strip, "Health for Better Living," produced by the Kellogg Company which sponsors the National 4-H Health Improvement Awards Program. The film provides ideas of what can be done on health in the 4-H program. Then Mabel Smith of the National

Committee on Boys and Girls Club Work explained the National 4-H Health Improvement Awards Program.

In general, it was felt that individual awards might be given on a national level, but more club awards should be given on the county level. The 4-H health program is under the direction of the county and State extension workers. It was pointed out that this health education provides opportunities for having group activities, and that these have proved to be effective because youth desires group approval.

Also, much progress has been made in shifting the health emphasis from the physical condition of the 4-H member as based mostly on appearance to emphasis on good health habits and activities performed.

The score card was brought up and the present system of scoring was criticized since it penalizes the boy and girl with physical defects. Iowa has tried to work out a score sheet with additional points for community activities, leadership activities, and others. Health improvement and health maintenance are as important as condition. In Wisconsin and other States, State medical associations give awards for outstanding health work, pay for trips to health camps, and provide demonstration awards.

How to integrate health education in the total 4-H program seems to be a main need. In Montana a program was developed to help the 4-H club member see the relationship between the feeding and health of calves in comparison with human nutrition and health. The caption "Your Calf and you Need....." was used to help the 4-H club member apply knowledge of nutrition to himself. In Nevada, boys and girls have been shown how the way an animal was fed affected the grade of meat produced. There was considerable feeling that in emphasizing special projects, such as livestock and clothing, the boy or girl is often forgotten.

The national 4-H trend is away from separate project clubs such as corn club, pig club, or cooking club. More and more clubs are mixed both as to sex and as to projects represented. This makes a better basis for definite health education in such clubs. There is also a definite trend toward playing down livestock awards. The health specialist needs to develop the health interest in 4-H work. Joint planning with other specialists will be required to develop and integrate health in the 4-H program. The trend toward more health in extension has made for some trend toward specialized 4-H health clubs. We were cautioned against going too far in putting health on the specialized project club basis, as it might discourage needed health education throughout 4-H work to all boys and girls.

4-H camps are excellent places for health activities. In Wyoming, posture was featured in the 4-H camps. In cooperation with the State department of Health, posture graphs were taken of each 4-H member. These were discussed with each individual. In Indiana multiple screening is conducted at 4-H camps, in cooperation with the State Public Health Department, which brings all its screening or testing instruments to camp, and mans them with personnel who know young people and who join with them in other camp activities. This

informal deeper acquaintance with doctors in camps was felt to be an important technique for helping build up favorable attitudes in children toward doctors and dentists.

A trend away from specific projects toward community health in the interest of building good citizens was commented on. It was suggested that 4-H tours of community and State health agencies and hospitals might be a good method of carrying out this type of health education, leading to knowledge and acceptance of community responsibility.

It was also emphasized that health cuts across all specialized areas. The health committee within the extension service was suggested as a way to facilitate the integration of health into other specialized fields as well as facilitating all health work within extension, using family and community approaches to health problems. Another good way to integrate with other related subjects is by informal contacts between the health education specialist and other staff members, jointly appearing on radio programs, jointly reviewing bulletins or newsletter manuscripts, and the like.

It must be recognized however, that the real place to teach good health habits is to children, and that too much stress cannot be put on this, in the long run. Home demonstration groups in many places can and are helping foster 4-H health programs, which helps to relate it and adult health work. Health is something all can work on together. 4-H health education has made great strides forward but needs further strengthening. Adult 4-H leader training is basic, and more is being done along this line. In many places 4-H Clubs have a health chairman as one of the club officers.

A very common 4-H club health activity is the physical-check-up. This is good. The main things are: (1) To be sure of getting a good check-up, (2) follow up on defects, and (3) plan cooperatively and ahead of time with the doctors and dentists.

J. E. Morrison, Colorado, Assistant State Extension Leader, stressed the point that we should:

Train State staff to be more health education conscious.

Train County staff to be more health education conscious, and in basic health facts and subject-matter.

Train local leaders - adult and 4-H.

Then continue training by pouring in the subject-matter, including health facts, how to analyze local health conditions and plan programs, and in preventative health subject-matter.

Put to work leadership that is available - State, County, local - and arrange or facilitate situations where people may learn and plan. The health educator specialist's job is subject-matter and organization technique.

## VI. THE EXTENSION HEALTH EDUCATION SPECIALIST AT WORK

Discussion led by E.J. Niederfrank. He pointed out that extension work may be dealt with under one or more of various frames of reference and that this session has to do primarily with some of the main methods and activities of the specialist. Needless to say, neither methods or content or any other aspect of extension work can be adequately discussed exclusively from one another, as all are related. We have frequently dealt with content in this and previous conferences, directly or indirectly. The content of extension health education has three main cornerstones - family health practices, community health services and group activities, and larger public programs that relate to health. People are interested in all three to more or less extent at given times.

The main thing is to decide upon the principal subjects that are to be stressed in a given year or period and then channel them into the methods and activities - the leader training, mass media, pilot case work, and others. Our task in this session, being careful to hold fast to the importance of content, is simply to look at certain main activities and methods of the specialist and talk about how we have or can improve our use of them in furthering the content that we are interested in at given times. Every extension person knows that skill in selection and use of teaching methods is basic to effective extension work.

Another point made was that we need to always think about what our teaching objectives are when deciding upon and using particular methods and activities. When you step to the microphone, or start to write a news item, or plan a talk for a group, or outline and open a leader-training meeting, what do you have in mind as the specific purpose to further or goal to accomplish by that particular radio talk or other activity? Main purposes to be furthered somehow are:

1. Motivation - create interest of people being contacted, getting acceptance of other habits and practices pertaining to subject.
2. Reach as many people as possible. Studies show that extension reaches best or most the people in the upper half of the local status scale, and that in many cases the folk needing our help the most "participate" in extension the least.
3. Provide subject matter and facts, as a basis for changing attitudes and practices pertaining to subject.
4. Determining felt needs of the people with whom we are working. All too often extension program planning does not get at the real needs and problems well enough. What methods are used and how we use them make a big difference.
5. Teaching for more understanding and use of available resources by the county staffs and people (form of subject matter).

6. Motivate and inform our own staff colleagues as well - Federal State, county - administrators, specialists whose programs are related to health.

Different purposes are better furthered by certain methods than others, and by different ways of operating them. Some methods are suitable for certain purposes but not so well suited for others. For example, when using the radio it is generally a good idea to include much to motivate and create interest but not to try to teach a great deal of technical information.

The group then divided into smaller groups of 2 or 3 persons each to consider various specific topics that pertain to methods, activities, or responsibilities of extension health education specialists with emphasis on What and How, after which they reassembled for general discussion. Below are their suggestions and comments by topics. 12/

The Specialist works with other agencies--State and county departments of health.

1. A first step is to develop administrative understanding of health education programs in Extension with public health as they apply to State and county levels:

Through letter from director of extension to health officer regarding health education in extension and employment of health education specialist.

Through asking health officer or other representative of health department to serve on advisory committee to health education committee within extension.

Through other means.

2. Become acquainted with personnel of health department.
3. Develop mutual understanding of each other's programs - (a) Objectives and goals, (b) Methods of approach, (c) Types of activities, (d) Administrative and operating channels, (e) Methods of evaluating progress in State or County.
4. Use as a main source of facts and subject matter. Visit regularly to obtain health information and exchange ideas.
5. Determine areas in which cooperation is possible and ways of cooperating.

Program planning -- Determining needs, Setting up objectives, Planning activities, Evaluation.

Preparation of materials - Bulletins and newsletters, Audio-visual materials, Other.

Help develop organization for securing health services.

Sharing in extension health teaching.

Cooperative projects in counties such as special services of Extension with welfare-case families; home demonstration clubs on a public health program or emphasis; cooperation in health conferences; work jointly on something like Chest X-ray.

6. Bring together county health department persons with county or district extension workers as opportunities arise. Make opportunities.

The specialist works with other agencies--medical societies

1. The Extension Director or some other designated administrative person to contact and interpret the Extension Service and its health education program to the State Medical Society.
2. The director of Extension to invite the Rural Health Committee of the medical society to meet with the health educator and himself or the extension health committee to discuss program.
3. The director of Extension to send written announcement of health education program to all public groups, including the State Medical Society; in turn they should be encouraged to inform their respective county units.
4. Develop procedure of personally conferring with Rural Health Committee, either as a group or individually, at fairly frequent intervals.
5. Secure names of county medical society officials, and in making contact in county through Extension agents, visit these medical officials and/or other leading doctors. Doctors on the other hand should feel a responsibility for contacting county agents and in turn rural groups; doctors should also feel a responsibility for taking part in the meetings and programs of rural groups. Help them to see and do these responsibilities.
6. Establish relationships with medical auxiliaries through personal conferences, meetings, programs.
7. Extension and medical profession each should accept their share of the responsibility in planning rural health activities in State, county and community levels; in giving and getting information on doctor distribution, problems; etc.
8. Whenever possible, try to encourage medical society on State or county levels to devote a part of their program time to interpretive talks by health educator, farm group representatives, or county agents.

The Specialist works with other agencies--special disease programs

A good many of the common diseases which affect man are the concern

of national organizations; for example; heart, cancer, tuberculosis, diabetes, mental hygiene, infantile paralysis, arthritis, cerebral palsy, crippled children, chronically ill, multiple sclerosis, eye, hearing, communicable disease, rehabilitation programs in connection with special diseases, and others. Main points are:

1. A health education specialist's responsibilities are to inform himself of the functions and services of these national organizations and interpret them to rural people. Have a file list of them, showing addresses of State headquarters and nature of State program. Consult regularly as to dates of their programs and how extension can help them reach rural people. They are a source of subject-matter information and materials also. Working with these organizations, we can help people recognize the early symptoms of these diseases so that they will consult their doctor for early diagnosis and treatment.
2. These teaching responsibilities are best carried out through group discussion at home demonstration club meetings, 4-H meetings, health councils, civic clubs, and other organizations; also at agent training sessions. It might be necessary for the health educator to prepare group discussion material based on material obtained from the health organizations, always submitting the material to the agency for approval.
3. In this role, the health education specialist keeps open the channels of communication between special disease agencies and rural people by interpreting the needs of rural people to the agencies and in turn interpreting to rural people the programs of these agencies. Extension agents or special disease organizations may also have problems in working with each other which you can help them straighten out and understand.

The specialist works with other extension staff members and committees

A basic task of the specialist is to develop other staff members in regard to his or her program and to get it into the county extension program. How to do all this might be dealt with in the next conference and that other specialists and people who deal with county planning be invited to participate. This was discussed at the 1951 conference and some good points on it are included in that summary.

A State extension health committee provides a good administrative channel through which the specialist can work, as previously mentioned. At any rate, every care should be taken to discuss and plan with other State staff members in activities that quite directly concern them, and especially with the district supervisors on the matter of developing the program in the county plans. Some specific suggestions are:

1. Have in mind the outline of what a county health improvement program ought to be and get it before extension people at every turn. Put it on a chart. A main thing for the specialist to remember is that all extension work is a county proposition, and that various programs have to be gotten into county program planning and into the hearts of the agents

and leaders. A good thing to do would be to prepare a brief outline which would describe the field and give the State and county staff members an idea of what a program in health improvement might be. This would be a stimulant to the staff and planning groups, and give them a helpful guide from which they might set up a packaged program for themselves from year to year. Offer to help them.

2. Try to get before district staff conferences. On such occasions let your emphasis be, not on "selling" your program but on finding out their experiences, difficulties, and interests. Explain program suggestions as to how it might be developed in county program planning. Make two or three recommendations for planning groups, or on things that are being emphasized.
3. Provide a health fact sheet or circular letter to State and county staff from time to time.
4. Volunteer to give individual help to agents, and to meet with county planning or other groups.
5. Discuss program field with county staff when in county - visit about problems in the subject, examples of things going on in the county, and the like. Make your county visit more than simply putting on an event. Get acquainted and give help to agents for their own understanding and work, for basically they are the ones to carry the program in the county. One thing you might help them on is to look over the health materials that come across their desk, and help them to appraise and use items or discard. Visit in a spirit of wanting to learn and of helping them think out answers, not in spirit of checking up or of giving out too many suggestions.
6. Supply counties with two or three bulletin items on health to add to their bulletin rack.
7. Show a personal interest in their work on program in county. Promise something and follow through on a bit of help by letter, by sending some material, or in some other way.
8. Work with State home demonstration and agricultural councils. Offer to help them appraise program, and make suggestions for their recommendation to the counties.
9. The specialist should also take the initiative if necessary in "conferencing" with other specialists through regular staff conferences, informal visits, and inviting other specialists to cooperate on special projects.

The specialist is responsible for assisting the health work of county staffs and committees; for training county staff through district conferences, informal conferences, newsletters, and other means. He should be available for conferences with local planning groups. He should provide suggested resources for county people—speakers, films, slides, bulletins and short bibliography.

The specialist speaks on the radio

In Utah a set of tape recordings for use over the whole State was developed during a short course in health and safety. Tape recordings have also been made of demonstrations in the State and of leader training meetings. The big objectives to further by radio are mass contact, giving out timely spot information and motivation. Its a place to push something being emphasized in program. Some specific suggestions are:

1. Interesting presentation -

Personalize - speak as if you were talking directly to one individual.

Examples.

Less by speeches and more by panels and interviews and skits.

Specific subject.

Emphasize specific points - not more than two or three - and make very clear.

Summarize the points.

2. What - timely, interesting, educational, inspiring, information.

Report and review of some event - leader training meeting, conference.

Presentation of some timely subject matter or State-county health facts. Place to push your emphasis in program. Tie or relate to extension program as a whole.

Explanation of a program or project.

Success story - family, community, county.

Share on other specialist radio programs.

3. Have ideas for radio broadcasts and take initiative in presenting to radio or information office, rather than waiting for them to ask you to broadcast. (May have to take turns or adjust to other policy.)

The specialist speaks at meetings

1. When - General occasions, such as at county achievement days; local organization meetings such as grange and farm bureau; 4-H camps; program planning meetings; county health council meetings; young farmers; homemakers' and farmers' institutes; annual extension meetings, county health improvement associations; service clubs; health workshops and conferences, and Career days.

2. What - Subject matter might include available health services, factual information, some special emphasis in program, health needs, community health, interpretation of surveys, success stories or result demonstrations, work of the health specialist, careers in health, specific problems such as brucellosis, civil defense health activities, special disease information, and other subjects.

3. How - interesting presentation - depends much on topic and occasion.

Organize around main points or frame of reference most appropriate for the occasion.

Visual aid - especially recognize value of the blackboard.

Emphasize specific points - not too many.

Plan for group participation - some kind of good discussion.

Relate to personal experience.

Arouse interest at beginning. Some ways are: (1) personal experience; (2) Raise critical questions or problems; (3) First get some experiences from floor, on what now doing; (5) Buzz session on what the main problems are; (6) List of questions or an agree-disagree quiz.

Always summarize.

Don't give more detail than is needed for the occasion.

5. The specialist should not be the presider of the meeting. Give the presider some background on self and of program or topic to be used in introducing you. Presider should relate topic or program to previous program planning and to extension work as a whole.

6. Leader-training meetings - some special suggestions

- (a) Interesting presentation - (see above).
- (b) Supply mimeograph copies of lesson or outline so leader can follow and make notes while you are presenting.
- (c) Don't present too much more detail than is needed or that leader can reteach.
- (d) Stress main points, ideas, facts.
- (e) Include one or more demonstrations or exhibit - that leaders can use in their meetings.
- (f) Always outline one or more specific activities or practices for leaders to apply and to teach. Help them



Use demonstrations in teaching.

Suggest method demonstrations to leaders.

Always aim to have some result demonstrations in mind to refer to in teaching or speaking or writing. Result demonstrations might be of a person, family, group, community, county. Be careful about referring to cases or demonstrations in the immediate place unless you are sure they are accepted and not ridiculed by the people you are talking to.

#### The specialist writes for newspapers

First the specialist needs to establish understanding with the press on interpretation of subject matter. General newspaper work of specialist, of course, should be handled in connection with information or editorial office of own institution. Remember that a main objective in use of newspapers should be motivation. And also, but to lesser extent is the giving of information. Some suggestions for newspaper items are:

1. Timely and interesting information; have specific points.
2. Names of individuals are important.
3. When meetings are announced, word should be given immediately to the paper; names should be included.
4. Report the meeting or event afterward, giving not just names and topic, but a brief of content. It's a chance to teach a bit of the same subject matter to others as well as to those who attended - a principle of repetition.
5. Specialist should talk or write to county agent on publicity to be given meetings, date, and topic.
6. Success stories also make good newspaper copy.
7. Remember that a photograph greatly helps.

A news awareness on health should be developed among 4-H, home demonstration, and agriculture leaders to encourage them to report items on health to local newspapers. All county agents should realize human interest value of health information for news stories. The press should be invited to attend some meetings.

Factual information that would appeal to the public should be prepared by the college information staff in cooperation with specialist. Pictures should be included. The specialist should cooperate with newspapers on health editions or special articles that are being planned.

#### The specialist gathers facts

Three types of facts are important. These are:

- (1) Related socio-economics facts about State and counties.
- (2) Facts that describe health conditions or problems and
- (3) Health subject-matter facts.

Among the sources of facts that may be used by the specialist are:

Hagood level-of living index by counties (now being revised)  
Sales Management (not always accurate)  
Social Legislation Information Service  
Journal of the American Public Health Association  
Today's Health (AMA)  
Journal of the American Medical Association  
Journal of Health Physical Education and Recreation (NEA)  
Public Health Economics  
Public Health Reports (US Public Health Service)  
Outlook Chart Book  
Publications of State health and welfare agencies  
WHO newsletter and other WHO publications distributed through  
Columbia University Press  
Extension Service Review

A folder for each county might be prepared to include statistics, news items and other data about the counties. (social scientists might help).

The specialist should get his name on mailing lists of health-related Federal and State agencies, public and private.

He should determine his responsibility for popularizing technical reports — especially own experiment station studies — to what extent is there a need for popularizing?

He may also participate on research committees, or help research people in planning and conducting researches, recognizing the difference between the extensive technical study and the perhaps non-technical exploration of the specialist. This cooperation helps the researcher handle practical problems needing research, and it helps the specialist in subject matter and to be scientific.

#### The specialist writes circulars and bulletins

##### Role of specialist

1. To prepare health education bulletins needed for extension health program.
2. To collaborate with other specialists on bulletins in specific subject-matter fields and get human health incorporated either in the body of the bulletin or in special section whenever it is appropriate.

##### Kinds of bulletins, circulars and leaflets

1. For whom: Extension staff information and guidance; project leaders; mass distribution to people both adults and 4-H boys

and girls.

2. Subject matter: Community organization for health; 4-H health bulletin (in cooperation with 4-H leaders); discussion and demonstration of special health problems such as brucellosis, cancer, first aid, home nursing, home safety; bulletin on timely recommended family health practices.
3. Monthly circular or newsletter or health fact sheet for extension agents to include current health information and activities in order to: (A) keep agents informed, (b) provide chance for exchange of ideas, (c) activate the health program, (d) give recognition for jobs well done.

#### How

1. For bulletin preparation, determine needs of people, survey available material of other agencies, prepare only bulletins that are not otherwise available or good for the purpose at hand.
2. Prepare bulletins according to priority of need.
3. Enlist cooperation and help of appropriate subject-matter specialists.
4. Assist other specialists in incorporating health into their bulletins.
5. Arrange on regional basis for interchange of bulletins through purchasing as published. (should be discussed at a later conference).

#### The Specialist writes newsletters and fact sheets

1. Source of material: Bureau of Census, all health agencies-official and voluntary, State medical society and State hospital association, State social welfare agency, other extension personnel, individuals, and others.
2. Purpose: Motivation; understanding; recognizing health and medical care and other problems; to show progress in control of disease and medical care; to establish new channels for information; promoting good public relations; to present and interpret subject matter; to provide items agents can use in talks or writings.
3. Content: Morbidity rates, numbers and cause of accident, causes of death, (compare national, State and local to gain interest); success case story, suggestions for club activities, suggestions for program planning, stressing of a particular health or safety practice, health and safety subject matter, other items for agents to use in talks and writings.

All newsletters and fact sheets should state the authority of factual information. Good public relations can be made or broken through seemingly innocent health information.

Newsletters should be fitted to current problems and interests of the agents or local people.

## VI. EVALUATION AND REPORTING

Four main types of evaluation, for purposes of discussion here

1. The continuous, informal, questioning mind.
2. General progress by observations and specific activity.
3. The systematic study of a specific activity.
4. Summary of county statistical and narrative reports.

Continuous, informal evaluation. There was general agreement as to the health specialist's need for continuous evaluation of his work, both from the point of view of definitely defined objectives and from the point of view of the methods he used to achieve them. Some evaluation is involved in planning work--the decision to stay in the office and prepare teaching materials versus going out to work in the counties, for example, is based on evaluation of the possible effectiveness of one method as against another in achieving a defined objective.

Planning for evaluation needs to be part of the development of a plan of work. Once a work plan has been carried out, there is a problem of testing the results in terms of whether or not the objective was reached -- to what extent were attitudes or behavior changed? Did the method used get the desired results? What were its good points? How could it be improved? Is it likely that some other method might have achieved better results in terms of fulfilling the defined objectives, reaching more people effectively, or other criteria?

The question was raised: "Should evaluation start from the roots up?" What is the effect of what we are doing on the families involved? How can we set a base line from which to measure our accomplishment? Do we need a "before" study in each case? The need for evaluation at different levels was briefly touched upon.

General indication of progress can also be obtained by specific observations and data from inquiry within the county. For examples:

- Number of counties accepting certain leader-training lessons.
- Number of new health councils aided.
- Number of county home demonstration councils recommending local club health activities.
- Number of clubs carrying out certain activities in a county, and kinds of activities.
- Number carrying a specific activity, such as cancer detection, or chest X-ray, or well testing.
- Number counties which include health in annual meeting or other event.

Number of county plans of work with specific plans on health.  
Change in attitude on part of State staff and agents.  
Number of cooperative activities with other staff.

Main steps in systematic evaluation of a specific item (example, leader-training meeting on home care of illness)

1. Must first know objectives or what one was trying to teach as it is change or activity in these that one is measuring. (a) Education is change in knowledge, (b) change in attitude, and (c) change in skills or things done. Examples:

To stimulate lasting interest in giving prompt attention and good care at sign of illness.

To get adoption of specified home care practices -- keep child home from school, plenty of rest, check and alter nutrition, etc.

To help leaders teach and show others these practices.

To teach sources of dependable information.

To teach people to evaluate health information they get.

2. Set up criteria for measuring the above -- number of specified practices applied, did child attend school when ill, did person teach at club meeting, were certain teaching methods used by leader, quality of response, number of neighbors who talked to others about lesson or practices later, etc.

3. Set up devices to be used in measurement -- survey questions, true-false quiz, check school attendance record.

4. Determine specific area of study -- how many persons, clubs or counties shall be covered and how shall they be selected?

5. Tabulate data, analyze and interpret findings.

Observations of some of the leaders who received the training to see just what part of the material and the methods presented they put to use was suggested as a possible "observation type" of device for evaluation. It was also suggested that district and county extension workers can help in determining progress.

Suggestions for revising county statistical report. In general the present statistical reporting form was considered inadequate to describe the accomplishments of the broadened extension health program. Few of the questions now listed apply to the health program in the broad sense in which it is now being developed. Among the areas not now covered are community or county work in the fields of health personnel, hospitals, prepayment, public health units, and group planning for health. More attention should be given to stating in terms of what counties do -- leader training, aid groups, encourage certain practices or activities.

If the philosophy of extension health work is to incorporate health throughout extension, some present references to health in various programs should probably be left where they are. On the other hand, would appear better to show as a separate section so as to bring out health as a program. Moreover, hard to report interrelations; also, other fields have interrelations, too, such as soils, crops, and conservation. Thus, this problem is not one of health alone.

Some questions, such as immunization, might be omitted or the question might be changed to refer only to the work of Extension. Others should be added, and more realistically stated.

It was suggested that in some States county workers summarize all health work in one section of their narrative report. Exchange of outlines of county narrative reports was believed necessary in order to develop a suitable form.

The new county statistical report form will necessarily have to be short; also designed so as to be usable for several years. Therefore, it must be designed so as to give a measure of the main things only so it will be adequate for States without needing separate State report blanks.

#### ALL EXTENSION WORKERS ARE MENTORS OF HEALTH -- A SUMMARY

Madge J. Reese 13/

At this conference, it has been said several times, that every Extension worker has a responsibility in health education. Aubrey D. Gates said that "99 percent of what Extension workers do reflects toward better health of rural people." All Extension programs, directly or indirectly have as an objective the well-being of people. There is not much "well-being" without physical and mental health.

In the Extension program, we work toward four improvements -- the improvement of agriculture, the improvement of rural homes, improvement of rural families themselves, and the improvement of communities. These are all closely interrelated and when we work in the interest of one we are working in the interest of the other three.

Disraeli said, "The health of the people is really the foundation upon which all their happiness and all their powers as a State depend." Does not that statement justify all that Extension workers and others do in health education? "All their powers!" Extension workers are convincing rural people more effectively that Better Health does mean: (1) greater economic welfare, (2) greater power in carrying out any responsibility, (3) greater power for that high production which the world expects of us, (4) greater happiness in sheer living and enjoyment of life.

We talk a good deal about changing attitudes. Learning is changing attitudes and living the changed attitudes. In home demonstration work we do much toward mental health without saying anything about health in some of the programs. Many a homemaker, because of new interests and activities, has stopped feeling sorry for herself and consequently has gained better mental health and often better physical health. One's philosophy of life and one's every-day religion has much to do with health.

An emotionally unbalanced person is an ill person. The idea of a well-adjusted person is something we can get over with 4-H Club members because self-improvement makes an appeal to the adolescent. Any devices we use with youth to encourage them to form good health habits, no matter how simple that they might be, count for something. Good sportmanship learned early in life pays dividends in later life in good mental attitudes and health.

Courage is a word we have heard several times at this conference. One early-day scientist said "At first all noble accomplishments seemed impossible." There are now 18 or 20 States with Extension health education specialists and a large number of the other States have Extension health programs. Not many other new Extension programs have made such progress in such a short span of years. Yet from experience in other fields of Extension effort that cut across other projects as health does, it has been found that it takes time to develop such a program. Extension workers have to be educated to best ways of incorporating health education into all programs.

Most health education specialists are good "generalists" in that they muster all available forces, public health services and others, to their aid in extending health education.

But there is much to do. It is sad when parents through ignorance, stubbornness or neglect let children grow up with physical defects which handicap and prevent buoyant health throughout life. Many times that happens for lack of money. It will be a happy day when adult education can reach into more homes. Fortunately through the schools, free clinics, and other health programs, physical defects in children are being detected and parents are being assisted in their correction.

You are pioneers in the field of Extension health education. Recruitment is an important word that has been heard at this conference. You can help much in letting it be known to other extension workers and to students what an interesting big field of work you have. I dare say that if 10 States would say tomorrow that we have money to employ health specialists, there would be difficulty in finding qualified workers for the positions. You can help to build your profession.

Before closing, I would like to pay tribute to two Extension workers who have given much leadership to health education in cooperative extension work. The first is the late Miriam Birdseye, nutrition specialist in the Federal Extension office for 25 years. Probably not many of you knew her. Miss Birdseye introduced the

term "optimum health" into Extension teaching. She coined the phrase "Be Your Own Best Exhibit" in 4-H Club Work. She laid the foundation for the hot school lunch program for the sake of health. Through Extension effort in many rural areas hot school lunches were made possible. She encouraged Extension workers to take the initiative in getting preschool clinics established in rural areas, and that physical check-ups of boys and girls be made possible at 4-H Club Camps. It was Miss Birdseye who advised all Extension workers to present the close relation of nutrition and health on every opportune occasion. Then more recently the late Elin Anderson made all Extension workers feel a larger responsibility in helping rural people to help themselves in getting adequate medical facilities and care in their own communities. To her, providing for good health was also a matter of public policy - local, State, National - as well as personal family health practices.

All of us are taking away from this conference renewed enthusiasm, added zeal, and much information, to say nothing about the good fellowship which has also helped to make this a successful conference. It has been one of the best that I have ever attended. You are in a big and interesting extension program. It will probably never be sufficiently manned. You will have to carve out some definite part for yourself and give what leadership to over-all health education you can, according to your own State situation and according to yourself. You are. And you are doing a grand job. More power to you all.

Most health education specialists are good "generalists" in that they master all available forces, public health services and efforts, to their aid in extension.

But there is much to do. It is sad when parents through ignorance, stubbornness or neglect let children grow up with physical defects which handicap and prevent bright health throughout life. Many times that happens for lack of money. It will be a happy day when adult education can reach into more homes. Fortunately through the schools, free clinics, and other health programs, physical defects in children are being detected and cures are being started in their correction.

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